IDAHO MEDICAID
HEALING ARTS THERAPY
PRIOR AUTHORIZATION REQUEST

To Requesting Provider:
Please complete form, attach required documentation and fax to (208) 332-7280

PLEASE FILL IN ALL BOXES - **ALL** INFORMATION IS REQUIRED

This request is for additional:

Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Today's Date:
Participant:
Medicaid ID #:
DOB:
Phone:
Requesting Provider:
Address:
City/Zip:
Phone:
FAX:
Provider Medicaid ID #:
Prior authorization requested for visits beginning (date): and ending:
Number of visits requested between these dates:
Brief Therapy Description, ICD -9, and CPT Codes:

The following supporting documents should demonstrate medical necessity for therapy service, and must be attached in order to receive prior authorization:

- ☐ Current Plan of Care, signed and dated by the physician (within the last 30 days for acute participants, or within the last six months for chronic participants) and specifying frequency, duration, and type of treatment.
- ☐ Most current therapy evaluation (dated within the past year).
- ☐ Progress report or re-evaluation (show improvement or changes with goals).
- ☐ Copies of therapy notes for all treatment within the last 30 days.
- ☐ Copies of IEP/IFSP therapy plans, if applicable.

Mail or Fax to: Division of Medicaid, Medical Care Unit
Therapy Reviews
PO Box 83720
Boise, Idaho 83720-0036

Phone: (208) 364-1904
Fax: (208) 332-7280

Once all documentation is received we will respond on or before the next business day.

Last revised 10-22-08